		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		7. 55.E5.NG.		c			
		011517	B. WING		05/22/2013		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
MAXIMUM HOME HEALTH CARE INC 8220 CALUMET AVE							
		MUNSTE	R, IN 46321				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE		
N 000	Initial Comments		N 000				
	This was a home hea investigation.	Ith state complaint					
	Complaint # IN00128337 - Substantiated: No deficiencies related to the allegation are cited. Unrelated deficiencies are cited.						
	Dates: 05/20-22/13	ates: 05/20-22/13					
	Medicaid #: 20093277	70					
	Surveyor: Janet Brandt, RN, PHNS						
	Quality Review: Joyce May 28,	e Elder, MSN, BSN, RN 2013					
N 522	410 IAC 17-13-1(a) P	atient Care	N 522				
	written medical plan of periodically reviewed	edical care shall follow a of care established and by the physician, dentist, rist or podiatrist, as follows:					
	agency failed to ensur were completed only care for 3 (#1, #2, #4	t as evidenced by: ord review and interview, the re visits and treatments as ordered on the plan of) of 4 records reviewed with all of the agency's patients.					
	The findings include:						
	-25-13, included a pla period 4-26-13 to 6-14 nurse one time per we	Start of Care (SOC) 2 n of care for the certification 4-13 with orders for skilled eek for 9 weeks. The record killed nurse visit was made					

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		A. BUILDING:		COMPLETED				
		011517	B. WING		C 05/22/2013			
NAME OF P	ROVIDER OR SUPPLIER	TE, ZIP CODE						
MAYIMIIN	MAXIMUM HOME HEALTH CARE INC 8220 CALUMET AVE							
WAXIIIO	THOME HEALTH GARL	MUNSTER	R, IN 46321					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE			
N 522	Continued From page	e 1	N 522					
	week 1, 4-26-13 to 4-	27-13.						
	plan of care for the ce 5-6-13 with orders for times weekly for 9 we evidence any skilled in 1, 3-8-13 to 3-9-13. Tone skilled nurse visit to 3-23-13; week 7, 4 8, 4-28-13 to 5-4-13 3. Clinical record #4, plan of care for the ce 4-24-13 with physicial visit 1 time weekly state health aide to visit 2 to 5-6-13 with order to the ce 4-24-13 with physicial visit 1 time weekly state alth aide to visit 2 to 5-6-13 with order to the ce 4-24-13 with physicial visit 1 time weekly state alth aide to visit 2 to 5-6-13 with order to 5-6-13	SOC 1-7-13, included a ertification period 3-8-13 to skilled nursing visits 2 eeks. The record failed to nurse visits were made week The record evidenced only twas made week 3.3-17-13-14-13 to 4-20-13; and week SOC 6-29-12, included a ertification period 2-24-13 to n orders for skilled nurse to arting week 2 and a home imes weekly starting week 2 8 weeks. The patient was						
	nursing visit was mad	iled to evidence a skilled le week 3, 3-10-13 to 3-16- o 3-23-13; week 6, 3-31-13 4-21-13 to 4-24-13.						
	B. A home healt during week 9, 4-21-1	h aide visit was missed 13 to 4-24-13.						
	4-25-13, after the cer after the patient was who performed a bloc resulting skin tear wit gauze dressing. The evidence an order for D. A home healt	h topical medication and a plan of care failed to these treatments. h aide visit was documented						
	period ended and after discharged.	3, after the certification er the patient was						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
011517		B. WING		C 05/22/2013		
NAME OF D	DOVIDED OD SLIDDI IED		DESC CITY STA	TE ZIR CODE	1 03/22/2013	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE						
MAXIMUN	I HOME HEALTH CARE I	NC MUNSTER,				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
N 522	Continued From page	2	N 522			
	4. On interview on 5-21-13 at 1:30 PM CST, Employee B stated, "I goofed and went to visit the patient after the certification period ended. On 4-25-13 I made a skilled nursing visit and I did a blood draw. The home health aide was also there. The patient experienced a skin tear probably because the skin was very fragile and the patient was on Coumadin [blood thinner]. I had the home health aide hold the patient's arm because of the tremor the patient had. That may have caused the skin tear; I don't know. I put wound cream on it and dropped a 4x4 gauze dressing on it and wrapped it in Kerlix. The day after the blood draw the family member called and indicated they wanted a different nurse to do visits [due to skin tear] but they wanted to keep the home health aide. We could not find another nurse to fit their scheduling needs so we discharged the patient effective 4-24-13, which was the end of the certification period, and I obtained the physician order to discharge effective 4-24-13 per family request."					
N 527	410 IAC 17-13-1(a)(2		N 527			
	promptly alert the per medical component o	The health care the home health agency shall teson responsible for the fif the patient's care to any the aneed to alter the medical				
	policy review, the age registered nurse notif	nedical record review, and ency failed to ensure the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		R WING		С	
		011517	B. WING		05/22/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
MAXIMUN	I HOME HEALTH CARE I	NC 8220 CALU MUNSTER			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 527	Continued From page	3	N 527		
	with the potential to a agency.	ffect all patients of the			
	Findings include:				
	the patient was dischanursing visit was doct the certification period was discharged, by E a blood draw and treatopical medication amplan of care failed to a treatments. The recophysician was notified 2. On 5-21-13 at 1:30 indicated there was not physician was notified nurse's treatment of the size of the would 3. The agency policy Response / Reporting #2-029.1 revised Octo	O PM CST, Employee B o documentation that the d of the skin tear and the he wound or documentation nd. "Monitoring Patient's g to Physician" policy ober 2011 states, "Policy:			
		sh and maintain ongoing he physician to ensure safe for the patient."			
N 537	410 IAC 17-14-1(a) S		N 537		
	provide nursing service	home health agency shall ces by a registered nurse or urse in accordance with the as follows:			
		t as evidenced by: ord review and interview, nsure drugs and treatments			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
011517		B. WING		C 05/22/2013				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
	MAXIMUM HOME HEALTH CARE INC 8220 CALUMET AVE							
IVIAAIIVIOIV	HOME HEALTH CARE I	MUNSTER	, IN 46321					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE			
N 537	Continued From page	2 4	N 537					
	were provided only as ordered on the plan of care for 1 (#4) of 4 records reviewed with the potential to affect all patients of the agency.							
	Findings include:							
	end of the certification visit was documented certification period en was discharged, by E who performed a blooresulting skin tear with gauze dressing. The evidence an order for 2. Employee B indicators nursing visit and bloorpatient #4 was dischard-25-13. Immediately done the patient was	was discharged 4/24/13, the n period. A skilled nursing on 4-25-13, after the ded and after the patient mployee B, skilled nurse, od draw and treated a n topical medication and a plan of care failed to						
	wound cream and drowrapped it in kerlix."	opped a 4x4 gauze on it and						
N 546	410 IAC 17-14-1(a)(1)(G) Scope of Services	N 546					
	are limited to therapy practice in the home in nurse shall do the foll (G) Inform the physic medical personnel of condition and needs, family in meeting nurse.	nealth setting, the registered owing: sian and other appropriate changes in the patient's counsel the patient and sing and related needs, e programs, and supervise						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		011517	B. WING		C 05/22/2013			
NAME OF PROVI	DER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE				
MAXIMUM HOME HEALTH CARE INC 8220 CALUMET AVE								
MAXIMUM HO	ME HEALTH CARE IN	MUNSTE	R, IN 46321					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE			
N 546 Co	ontinued From page	5	N 546					
Ba po reg pa wiii ag Fir 1. the nu the wa a t top pla tre ph 2. inc ph nu of 3. Ref #2 Cli co	dicy review, the ageing gistered nurse notification tient's wound for 1 (ath the potential to after the potential to after the potential to after the patient was discharged, by Englood draw and treation and are failed to eather the potential to a potential medication and an of care failed to eather the size of the wound the size of the wound the agency policy as ponse / Reporting 1-029.1 revised Octobicions will establish	redical record review, and ancy failed to ensure the ed the physician of a a #4) of 4 records reviewed fect all patients of the care 6-29-12, evidenced arged 4-24-13. A skilled amented on 4-25-13, after a ended and after the patient and a resulting skin tear with a gauze dressing. The evidence an order for these ard failed to evidence the of the skin tear. PM CST, Employee B of documentation that the ne wound or documentation and. "Monitoring Patient's to Physician" policy ober 2011 states, "Policy: the and maintain ongoing the physician to ensure safe.						

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